

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-033655

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 525

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 17 1962

VS 300
Rev. 4/59

1109
20660
3
4 0
5 0
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7 0
8 2
9 1930
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12 2-0
13 3-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>BOONE</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>MILLER</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>COLUMBIA</u> | | Length of stay in lb <u>14 days</u> | c. CITY OR TOWN <u>DIXON</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>UNIVERSITY</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>RT. 3</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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|--|-------------------------------|---|---|--|--|
| 3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>DEWAYNE</u> Last <u>BELK</u> | | | 4. DATE OF DEATH Month <u>9</u> Day <u>14</u> Year <u>1962</u> | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-31-61</u> | 9. AGE (last birthday) Months <u>9</u> Days <u>14</u> | IF UNDER 24 HR Hours <u>14</u> Min. |

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|---|-----------------------------------|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>IBERIA, MO.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u> |
|---|-----------------------------------|--|--|

| | | |
|--|---|-----------------------------|
| 13a. FATHER'S NAME <u>HENRY BELK</u> | 13b. MOTHER'S MAIDEN NAME <u>ZELPHA HELTON</u> | 14. NAME OF HUSBAND OR WIFE |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. |
| 17. INFORMANT <u>U.M.M.C. Chant Columbia Mo</u> | | Address |

| | | |
|--|------------------------------|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Ependymoma</u> | <u>UNKNOWN</u> |
| DUE TO (c) | | |

| | | | |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
|---|--|--|--|

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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
|---|---|--|--|

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|---|---------------------------------|
| 20c. TIME OF INJURY Hour <u>6:05</u> a.m. / p.m. | Month, Day, Year <u>9/14/62</u> |
|---|---------------------------------|

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|--|--|---|-------------------------|---------------------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION <u>COLUMBIA</u> | COUNTY <u>MILLER</u> | STATE <u>MO.</u> |
|--|--|---|-------------------------|---------------------|

21. I attended the deceased from 9/14/62 to 9/13/62 and last saw her alive on 9/13/62 at 10:00
Death occurred at 6:05 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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|--|-------------------|--|------------------------------------|
| 22a. SIGNATURE <u>Roland Joel HARRIS MD</u> | (Degree or title) | 22b. ADDRESS <u>University Hospital Columbia Missouri</u> | 22c. DATE SIGNED <u>9/14/62</u> |
|--|-------------------|--|------------------------------------|

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|--|-----------------------------------|--|---|---------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>SEPT. 16/1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>IBERIA CEMETERY</u> | 23d. LOCATION (City, town, or county) <u>IBERIA MO</u> | (State) |
|--|-----------------------------------|--|---|---------|

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|--|---------|---|---|
| 24. FUNERAL DIRECTOR <u>Sharon No</u> | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>Sept 14 1962</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs RE Palmer</u> |
|--|---------|---|---|

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

J. L. Stevenson

Licensed Embalmer No.

4073

P. O. Address

Stoner No.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.